AFFIDAVIT OF APPLICANT FOR DISABILITY BENEFIT

State Form 21703 (R4/7-04)
Approved by State Board of Accounts, 2004
Indiana State Teachers' Retirement Fund
150 W. Market St., Ste 300
Indianapolis, IN 46204-2809
Telephone: (317)232-3860 Toll Free 1-888-286-3544 FAX (317)232-3882
http://www.state.in.us/trf

PRIVACY NOTICE

Your Social Security Number is being requested by this state agency in accordance with the requirements of IRS Code 3405. Disclosure is mandatory and this document cannot be processed without it.

PART 1 – APPLICANT DATA

Name (*first, middle, last*)		Social Security number	TRF number
Address (*number and street or PO box, city, state, zip*) New Address ☐		Date of birth (month, day, year)	Telephone number ( )
		Last day, active teaching service	Last teaching position
Years of Indiana teaching service	Other creditable service	Date you began covered service	Your age at beginning service
Last employer		Employer city or TWP	Employer county
President of Board or Trustee of last employer		Superintendent of last employer	
Address of president or trustee of last employer		Address of superintendent of last employer	

PART 2 –MEDICAL INFORMATION

Date medical condition began	Date you were compelled to give up your teaching position	Date you first consulted a physician for this condition	Date your last school year ended
Date your next school year starts	Date a half school year will have elapsed since you quit teaching	Time lost during last teaching year because of condition	Earnings, if any, since you ceased public school work
Name of attending physician you first consulted for this condition		Address of attending physician	

How did your disability begin? State full all the symptoms and describe your condition from beginning of trouble:

Are you confined to bed?	Are you confined to house?	Date such confinement, if any, began	Do you expect such confinement to continue?

Describe in detail to what extent you are incapacitated from following the teaching profession

What ailments, diseases, illnesses, disorders, infirmities, disabilities or injuries have you had in the last five years? (*Give complete facts, dates of attack, name and address of any physician who attended you in each case.*)

Have you ever been an inmate of a hospital, asylum, sanitarium or heath resort of any kind? (*If so, give dates, sites, and other particulars.*)

During the last five years have you received a pension from any source, or benefits from any accident or health insurance company or association? (*If so, give dates, names, addresses, and full particulars.*)

Give name and address of each and every physician and/or specialist consulted by you during the last three years.

Have you made claim to any insurance company for benefits because of your condition? If so, give name and address of each such insurance company.

Are you able to appear before the examining physician in Indianapolis?	If not, can you appear before an examining physician in your area?

I hereby make application for disability benefits under the provisions of the Indiana State Teachers' Retirement Fund law on account of physical or mental disability which incapacitates me from service as a teacher in the public schools of Indiana.

STATE OF _____ }

COUNTY OF _____ }

I, _____, do solemnly swear that the foregoing statements are full, complete and true in every respect, and that I have not withheld and information material to the case which, if disclosed, would alter, change or modify the facts above set forth.

Applicants signature_____

Subscribed and sworn before me this _____day of _____20_____

Notary Public Signature_____

Notary Public Name Printed_____

My Commission Expires _____